


Ethical Issues in Delivering Psychological Therapies in Geriatric Psychiatry in India

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The characteristic of the population worldwide is changing dramatically with an ever-increasing number of older persons. It is anticipated that by 2050 there will be more persons aged 60 and above than those aged 16 and below, and those over 60 years will constitute 22% of the total population.^{1,2} India, like the rest of the world, has witnessed a continuous rise in the number of elderly, as the number of persons over the age of 60 has tripled in the previous 50 years.³

With the rising numbers of older persons, the burden of associated mental illnesses also is potentially increasing. The lifetime prevalence of mental health problems in persons aged 60 and above in India is estimated to be 15.11% (14.95%–15.27%) according to the National mental health survey, 2016.⁴ Current worldwide estimates for the number of persons with dementia is 50 million and is expected to increase to 152 million by 2050, with a significant increase among the low- and middle-income countries.⁵ In India, it is estimated that about 5.3 million people

have dementia now, and an increase of over 10 million is expected by 2040.⁶ The elderly are also at increased risk of abuse and neglect.^{7,8} Furthermore, increased prevalence of associated medical illnesses, sensory impairment, increased financial and functional dependency, abuse, and neglect increase the vulnerability of the elderly population to mental health problems.^{9,10}

Mental health care professionals are guided by the codes of ethics and professional guidelines when delivering interventions.^{11–13} Advancing age, associated physical impairments, mental illness, cognitive impairment, gender issues, lower levels of literacy, and socioeconomic status may influence the mental capacity of the older person.¹⁴ The changes in the mental capacity and the unique issues mentioned above can pose significant ethical challenges in providing interventions to this particular population.

We use cognitive stimulation therapy (CST) as an exemplar to highlight the ethical challenges in delivering psychosocial interventions for elderly persons

with mental illness. CST is a manualized, theme-based, brief, evidence-based, and cost-effective group psychosocial intervention for persons with mild to moderate dementia involving 14 sessions over 7 weeks.^{15,16} It has been adapted for use in India and is currently being studied for implementation in low- and middle-income countries, including India.^{17,18}

This article highlights the ethical challenges in delivering CST for persons with dementia in India and discusses an ethical decision-making model to guide the practitioners when facing such challenges.

Ethical Principles

In their seminal work, Beauchamp and Childress established the “Principles of Biomedical Ethics,” highlighting the importance of beneficence, nonmaleficence, autonomy, and justice.¹⁹ Kitchener adopted these principles for application in psychology while including the concept of fidelity.²⁰

In the context of providing interventions for elderly with mental health

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problems, Fitting described fidelity, autonomy, and beneficence as the core “principle” ethical concepts that are binding, suggesting that each should be upheld and should be “overridden only if there is a strong moral obligation.”²¹ The concept of fidelity deals with the quality of the relationship between the therapist and the client. Trust and loyalty are the hallmark features of this professional relationship. Autonomy describes the right of the elderly client to make decisions and choose options regarding matters that affect their lives, including their treatment. The elderly client should be involved in the decision-making process and should not be railroaded by others. However, Asian societies accord cultural importance to collectivism. The individual is not seen as a separate entity but part of a larger network such as the family or society. The principle of autonomy may be difficult to adhere to. Furthermore, the respect accorded to the elderly in Asian cultures may also influence autonomy as an ethical principle in certain circumstances. Beneficence refers to the need for therapists to prevent any harm to their clients and primarily keep the clients’ best interests in the forefront when evaluating decisions.

In addition to the aforementioned three principles, nonmaleficence, justice, and general beneficence have been described as important biomedical and moral-ethical principles.^{22,23} Nonmaleficence is related to beneficence, and it defines the concept of doing no harm to the client. It dictates that the mental health practitioner should not cause any harm to the client by delivering any intervention, or the harm should not be disproportionate to the benefit of the intervention. It also states that the mental health practitioner should not allow harm to be caused to the client through neglect. The principle of justice relates to the importance of providing fair, equitable, and appropriate treatment for the clients as needed by them. General beneficence identifies the importance of the therapist’s responsibility to society and the public at large.

While the described “principle” ethical concepts are considered obligatory, “virtue ethics” deals with the character traits and nonobligatory ideals that facilitate the health care professional to choose the principle based on their moral

values.²⁴ Virtue ethics complement the principle ethics and helps the individual therapist to choose the most appropriate principle when two or more principles conflict.²⁵

Ethical Challenges

Mental health practitioners working with elderly clients are likely to face ethical challenges under the following circumstances:^{22,26}

1. When there are competing ethical principles.
2. When ethical, legal, and/or organizational requirements are pitted against one another.
3. When facing a relatively new area of clinical practice and the ethical codes or laws do not provide adequate guidance.
4. When the practitioner is required to rely on his/her judgment.

Geriatric mental health practitioners commonly face ethical challenges in their day-to-day work in the context of completing assessments, delivering interventions, providing consultations in hospitals or care homes, and when conducting research. We present a few scenarios commonly encountered in our clinical practice delivering psychological interventions for the elderly with dementia that highlight the ethical challenges.

Challenge 1: Participation in Psychological Interventions

Mr M was diagnosed with moderate dementia in Alzheimer’s disease, late-onset, and was recommended to attend group CST sessions. Though he agreed to attend and participate in the CST sessions when discussed in the clinic, he was resistant when he started attending the sessions. His wife, the primary caregiver, reported that he complained about the long travel to the center and was reluctant to get ready to come to the sessions. His wife persuaded him, made the necessary transportation arrangements, and accompanied him for the sessions. During the first few sessions, he asked to leave soon after he arrived at the center. He also appeared to be anxious and uncomfortable. Persuading him to attend and not to leave the sessions, introducing a new activity or a new member to the group

were often met with irritation and anger. He, however, could not clearly explain the reason for his anxiety, discomfort, and anger because of his cognitive difficulties. We presumed after discussing with his wife that these symptoms were probably because of the new environment and the presence of strangers. Given his reluctance to participate, we asked him if he would like to stop attending the sessions. While he was ready to stop, his wife mentioned that he was usually slow to warm up to strangers and new situations and asked if he could come for a few more sessions, and if he continued to be reluctant, we could stop his participation. She also mentioned that he seemed more alert and communicative on the days that he attended the sessions after reaching home.

Mr M was benefiting from attending the CST sessions, though he remained a reluctant participant. We asked the wife not to force him to come but to encourage him gently to attend the sessions. Over the next two weeks, Mr M appeared more relaxed during the sessions, and his wife mentioned that he was looking forward to the sessions. He participated more actively during the sessions over time.

A common ethical dilemma in the clinical practice of geriatric mental health practitioners is the requirement to balance the patients’ autonomy with their welfare (beneficence).²⁷ While the practitioners wish to support their patients’ rights to make independent decisions regarding their treatments, often, when patients are incapacitated and their decisions can be contradictory to their welfare, the practitioners find it challenging to support these decisions. In these circumstances, awareness about the patients’ lifetime values and wishes can help resolve the conflicts.

Challenge 2: Delivering Group Psychological Interventions

Mrs N is a retired head-teacher with vascular dementia. She has always been an independent and strong-willed person. While participating in CST groups, she was often dominant and sometimes dismissive of other participants. She also had been noted to be more disinhibited in her speech and behavior, making rude remarks about the mistakes other

participants make and about their appearances. Despite the facilitators' efforts, Mrs N continued to disrupt the group. Her family reported that she appeared to benefit from attending the sessions as she was happier at home and looked forward to the sessions each time. However, other participants were less participatory around her, and they also started complaining about her behavior.

In this instance, while Mrs N benefited from the intervention, her participation in the CST harmed the other participants. While her behavior may have been driven by disinhibition secondary to the neurodegenerative processes intrinsic to vascular dementia, the ethical challenge for the geriatric mental health practitioners is to balance the "autonomy" of Mrs N, the "beneficence" of receiving the intervention, and the code of "non-maleficence" towards other participants. After a discussion with Mrs N and her family, she was offered individual CST sessions. She continued to meet the group that she was part of initially, on an informal basis, during her visits to the center but was moved to a separate room for individual CST.

Challenge 3: Discontinuing Interventions

Mrs S is an elderly lady with dementia in Alzheimer's disease, late-onset. She completed one round of CST and a round of maintenance CST.²⁸ Following these, she continued to come to the center once every week for nearly two years, and she was participating in the weekly maintenance CST sessions. Over time, it was evident that her cognitive functions and activities of daily living were declining. She could no longer participate meaningfully in group activities. This appeared to negatively impact other participants in the group, as the facilitators were spending more time helping Mrs S and other participants felt ignored. However, her family reported that she appeared to enjoy being out of the house. On the days that she attended the sessions, she was more cheerful. While being aware of the futility of the maintenance CST for Mrs S, the facilitators of the group also believed that socialization and being out of her house helped her emotionally. It was agreed that maintenance CST might

not be the best option just to provide socialization. After a discussion with her and her family, she was shifted to another group that met every week just for socialization. She appeared to enjoy this new group and continued to attend regularly.

More specifically, for the mental health practitioners working with older adults, the ethical principles of "futility of treatment" and "non-abandonment" become relevant in their routine practice.²⁶ With advancing dementia or changing circumstances, specific interventions may become futile. Under such situations, the therapist must recognize the "futility of treatment" and aim to modify or discontinue interventions when their patient no longer benefits from the interventions. "Non-abandonment" refers to the therapist's responsibility to ensure that appropriate care is provided to the patient that is beneficial and not harmful to them. In the case of Mrs S, it was decided that continuing maintenance CST was futile, and attending a "socialization group" was more appropriate and fitted with the principle of "non-abandonment."

Guiding Practitioners Towards Delivering Ethical Psychological Interventions for Elderly

A structured ethical decision-making process can help mental health practitioners working with the elderly when facing ethically challenging situations, as described before, to choose an appropriate course of action. Identification of the problem, development of alternatives, evaluation of alternatives, implementation of the best option, and evaluation of the results have been identified as necessary five steps to review several ethical decision-making models.²⁹ We found that a specific ethical decision-making model proposed by Bush, Allen, and Molinari has integrated elements from various other such models most helpful in our practice.²⁶ The model includes the following seven steps (mnemonic CORE OPT):

Clarify the Ethical Issue

The crucial first step is to analyze the clinical situation and clarify the

challenging ethical issues. Often the challenge is in balancing the competing ethical principles of patient autonomy and beneficence.

Obligations Owed to Stakeholders

Identifying the obligations towards the various stakeholders pertinent to the situation while keeping the patient at the center of all decision-making processes helps in understanding the relevant ethical challenges within context.

Resources

The following necessary process is to identify appropriate resources that can help and guide the ethical decision-making process for the practitioner. Four issues have been identified as necessary in delivering ethical psychological interventions for the elderly: professional competence, balancing the ethical principles, limitations in the evidence base for various assessments and interventions, and working with interprofessional teams and families.²⁶ Mental health professionals must be competent in delivering psychological interventions. The guidelines developed by professional bodies and awareness of legal requirements can help the practitioners navigate the ocean of professional practice. Also, regular supervision and self-evaluations act like lighthouses and compasses to help the professionals safely negotiate the challenging courses and assist them in delivering ethically balanced interventions. Resources like the Pikes Peak Competencies Assessment Tool can assist in this regard.³⁰

In India, the National Medical Council has stipulated that all medical practitioners are required to follow the code of medical ethics, including codes for the character, conduct, quality of care, and reporting of unethical conduct or care.³¹ It also recommends that medical practitioners should follow the law of the land. Specifically for the psychiatrists, the Ethics Subcommittee of the Indian Psychiatric Society has stipulated 13 principle code of ethics statements. These include the patient's wellbeing being the paramount criterion of treatment, professional competence, maintenance of discretion, consultations, and collaborations with professional colleagues

as needed, maintenance of professionalism in all interactions, maintenance of patient rights and confidentiality, regular knowledge updating, treating other professionals respectfully and acting appropriately when encountering unethical actions of another professional, upholding the dignity of the medical profession, raising awareness about mental illness among the general public, adhering to the ethical principles of academic and research conduct, and abiding by all the laws that apply in the context of one's clinical work.¹²

The Mental Health Care Act 2017 that came into force on 29 May 2018 in India has specific provisions that influence the delivery of interventions for the elderly with mental illness.^{29,32} The "Advance Directive" offers persons with mental illnesses the opportunity to communicate their wishes regarding the care and treatment being provided to them in the future and the choice of individuals for appointment as the nominated representative when they lose their capacity to make decisions for themselves. Persons with dementia who still retain the capacity to make decisions regarding their care and treatment should be encouraged to make advance directives and every attempt should be made to include their caregivers in this, who are appointed as the nominated representatives in the discussions regarding the care and treatment.

The practitioners must endeavor to update themselves with the available resources relevant to their practice and use them when necessary. From our review of the literature, we noted a shortage of specific resources for geriatric mental health clinicians in India to guide their ethical practice, an issue highlighted by others as well.³³

Examine Personal Beliefs and Values

Often, when competent professionals deliver interventions, they need to be aware that their values and mores do not take precedence over their patients. The character traits of the practitioners and their moral values, the concept of "virtue ethics" as described previously, should help guide them in choosing the appropriate course of action.^{24,25}

Options, Solutions, and Consequences; Put the Plan into Practice; Take Stock and Evaluate

Once an appropriate plan is made to manage an ethically challenging situation, the next obvious steps are to put the plan into action and evaluate the outcomes. Documenting all the processes involved in arriving at the plan, communicating the plan to all the relevant stakeholders, systematically executing the plan, and evaluating the outcomes will help the mental health practitioner to learn from the process and to stand up to any scrutiny that they may face regarding their decisions.

Positive Ethics

Mental health practitioners need to act to avoid ethical misconduct in their professional practice. A better method recommended to achieve the highest standards of professional conduct is the "positive ethics" approach.³⁴ This can be accomplished by applying the ethical principles proactively in routine clinical practice by anticipating ethical challenges, avoiding potential ethical misconducts, and addressing the ethical challenges appropriately when they are anticipated or encountered.³⁵

Conclusion

In this article, we highlighted common ethical issues and challenges encountered by mental health practitioners delivering psychosocial interventions for elderly persons with mental illness. We provided some scenarios portraying ethical challenges from our experience in delivering CST for persons with dementia and discussed a decision-making model that may guide the clinicians to deal with such situations. Using the "positive ethics" approach in routine clinical practice can help practitioners achieve and sustain high standards of professional conduct. Also, much work is needed to systematically collate available resources such as guidelines and legal regulations relevant to the practice of geriatric mental health professionals in India.

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